



## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor Name and Address:	MFDR Tracking #: M4-09-0248-01
USMD HOSPITAL AT ARLINGTON 801 W I-20 ARLINGTON TX 76017	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:	Date of Injury:
CONTINENTAL INSURANCE CO Box #: 47	Employer Name:
	Insurance Carrier #:

### PART II: REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We are requesting that you review our claim because Coventry did not pay the surgeries according to the APC's and the implants were not paid. Coventry requested the certified letter for the implants because the first letter could not be located by Coventry. I faxed the certified letter on August 12, 2008 and the reconsideration was denied. "

**Amount in Dispute:** \$8,918.10

### PART III: RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The Requestor is not entitled to additional reimbursement under subsection g because it did not comply with the Rule. As evidenced by the copy of the check enclosed in Ex. G, the Carrier paid the provider the billed amount for the disputed services in the total amount of \$4,357. When the HCP submitted the original documents a Certification Letter... was not included... As a result, the Carrier issued an Explanation of Review requesting the missing certification letter... The HCP submitted a second set of documents which included two additional pages of medical records but did not include a certification letter... Responsively, the Carrier issued an Explanation of Review indicating this was a duplicate submission. Carrier's URA, Coventry, received additional documents directly from the HCP on July 8, 2008, but no Certification Letter was included. A Revised Explanation of Review was issued indicating that the "previously requested state-required implant cost certification was not submitted". On August 7, 2008, the Carrier's bill review company received a telephone call from the provider requesting the bill be reviewed as the bill was not a duplicate bill. In addition, the provider asserted that the requisite certification letter had been sent. Documentation of this phone call is attached as Ex. G. As indicated in Ex. G, additional research was required to ascertain if the letter had been sent. The research was done and the another [sic] Revised Explanation of Review was issued asserting the same rationale. No such certification letter was received. The first time Carrier received this Certification Letter was in the HCP's D60 Request submitted in September 2008. Carrier requests that TDI DWC dismiss this medical dispute as payment has been made in the billed amount. No additional reimbursement is owed as the HCP is not entitled to separate reimbursement for the implants for failure to comply with Rule 134.403(g)(1)."

### PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
05/02/08	Hospital Outpatient Services	$\$7,969.92 \times 130\% = \$10,360.51 + \$352.60$ (implants) - \$4,357.00 (carrier payment)	\$8,918.10	\$8,918.10
<b>Total Due:</b>				\$8,918.10

## PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital outpatient services.

This request for medical fee dispute resolution was received by the Division on September 17, 2008..

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
  - 193 (920-002) – Original decision is being maintained. Upon review, it was determined that this claim was processed properly. In response to a provider inquiry, we have re-analyzed this bill and arrived at the same recommended allowance.
  - 16 (855-022) – Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Charge denied due to lack of sufficient documentation of services rendered.
  - 58 (729-001) – Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. This service is not reimbursable in a hospital outpatient setting.
  - 97 (243) – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. This procedure has been included in another procedure performed on the same day.
2. Division rule at 28 TAC §134.403(e) states, in pertinent part, that “Regardless of billed amount, reimbursement shall be:
  - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
  - (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;”
3. Pursuant to Division rule at 28 TAC §134.403(f), “The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.
  - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
    - (A) 200 percent; unless
    - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.”
4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services are classified into groups called Ambulatory Payment Classifications (APCs). Services in each APC are clinically similar and require similar resources. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Packaged services are considered integral to the primary paid service and are not separately reimbursed. An OPPS payment status indicator is assigned to each HCPCS code. The status indicator for each HCPCS code is shown in OPPS Addendum B, and a full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year, both of which are publicly available from the Centers for Medicare and Medicaid services.
5. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:
  - (1) No documentation was found to support a contractual agreement between the parties to this dispute;
  - (2) MAR can be established for these services; and
  - (3) Separate reimbursement for implantables was requested by the requestor in accordance with TAC §134.403(g)(1).
6. According to Medicare, CPT Code 63650 x 2 is a Status S code. The Status S code is an outpatient significant procedure not subject to multiple procedure discounting. Additional reimbursement is recommended.
7. The Requestor asked for separate reimbursement for implantables. The Respondent alleges that a copy of the certification letter was not submitted until a dispute was filed. According to TAC §134.403(g)(2) a carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR

of Fee Dispute), if that process is properly requested, notwithstanding 133.307(d)(2)(B) of this title. The Division concludes that the documentation submitted sufficiently supports that a representative of USMD properly attested to the certification of the implant bill.

8. Consequently, reimbursement will be calculated in accordance with Division rule at 28 TAC §134.403(f)(1)(A) as follows:

APC	Outlier Amount	Separate reimbursement for implantables WAS requested under Rule §134.403	APC X 130%	Fee Schedule (CMS x DWC conversion factor)	Less amount paid by Respondent	Additional amount due Requestor
\$7,969.62	\$0.00	\$5,352.60	\$10,360.51	\$0.00	\$4,357.00	\$8,918.10

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code §413.031(c), the Division concludes that the requestor is due additional payment. As a result, the amount ordered is \$8,918.10.

#### PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311  
28 Texas Administrative Code §133.305, §133.307, §134.403  
Texas Government Code, Chapter 2001, Subchapter G

#### PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$8,918.10 plus accrued interest per Division rule at 28 TAC §134.130 and §413.019 (if applicable), due within 30 days of receipt of this order.

#### DECISION/ORDER:

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Auditor III  
Medical Fee Dispute Resolution

\_\_\_\_\_  
Date

#### PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**